

STATEMENT OF HEALTH – HORSES ONLY

Producer's Name	All American Horse Insurance Agency	Applicant's Name	
Agency Code	87-220828	FEIN or SOC SEC #	
Mail Address	PO Box 300384	Mail Address	
City, ST Zip	Glenwood, UT 84730	City, ST Zip	
Phone	Ph: 435-896-4593	Phone	() -
Fax	Fax: 435-893-0920	Fax	() -
E-mail Address	allamericanhorseinsurance@gmail.com	E-Mail Address	

**This Statement forms part of the Animal Mortality Application.
Valid only on horses ages 1 to 16 years with a value of \$25,000 or less.
(To be completed by the applicant.)**

Horse (1) Name _____	Horse (2) Name _____	Horse (3) Name _____
Use of Horse (1) _____	Use of Horse (2) _____	Use of Horse (3) _____
How long have you known Horse(1)? _____	How long have you known Horse(2)? _____	How long have you known Horse(3)? _____

(If you have known horse(s) less than 30 days, this form is not applicable and a Veterinarian's Statement is required.)

- | | <u>Horse (1)</u> | <u>Horse (2)</u> | <u>Horse (3)</u> |
|---|--|--|--|
| 1. Is the horse currently free of lameness and healthy, without the use of drugs, for the use intended?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have you observed the horse in all gaits involved in its intended use?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Does the horse have any past conformational problems or defects, illness or disease, lameness, injury or physical disability including but not limited to: laminitis/founder, OCD, neurological disorders e.g. EPM, navicular disease and/or degenerative joint disease?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Has the horse had any colic, impaction, colic surgery or intestinal disorder within the last 36 months?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Has the horse listed been vaccinated for the West Nile Virus?.....
If Yes, provide date of first vaccination and date of booster below. | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Has the horse been HYPP tested?.....
If Yes, please check result: Horse(1) <input type="checkbox"/> N/N <input type="checkbox"/> N/H <input type="checkbox"/> H/H Horse(2) <input type="checkbox"/> N/N <input type="checkbox"/> N/H <input type="checkbox"/> H/H Horse(3) <input type="checkbox"/> N/N <input type="checkbox"/> N/H <input type="checkbox"/> H/H | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Has the horse been nerved or received any surgical treatment for lameness?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Has the horse been examined or treated by a veterinarian for other than routine care within the last year?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Has the horse undergone diagnostic ultrasound, bone scan or x-rays within the last 36 months?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Has the horse received any joint injections, any type of medication long or short term, or any preventative treatments in the last 24 months?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Is the horse due to foal any time during the proposed policy period?.....
If Yes, give estimated foaling date along with the number of previous foals. | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Was a pre-purchased exam done?.....
If Yes, a copy of results may be requested by Company. | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. If Yes is marked as the answer for any horse in questions 3 through 12, please provide details below..... | | | |

I declare the above statements are true and complete, and that no material information was withheld.

Applicant's Signature	Date: (Must be no more than 30 days prior to policy effective date)
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